



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

ORTHOTEXAS PHYSICIANS AND SURGEONS  
4780 NORTH JOSEY LANE  
CARROLLTON TX 75010

#### **Respondent Name**

NEW HAMPSHIRE INSURANCE CO

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-12-1595-01-01

#### **MFDR Date Received**

JANUARY 13, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "On date of service 4.11.11, the office visit of 99203-25 was denied stating the documentation submitted does not support the services rendered. I have attached the documentation for your review. As you will see, we did meet the qualifications to be able to bill this office visit."

**Amount in Dispute:** \$143.68

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** The respondent did not submit a response to this request for medical fee dispute resolution.

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 11, 2011	CPT Code 99203	\$143.68	\$0.00
TOTAL		\$143.68	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputes service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 150-Payer deems the information submitted does not support this level of service.
- Z710-The charge for this procedure exceeds the fee schedule allowance.
- VF01-Docuementtation does not support level of service billed.
- X394-Our position remains the same if you disagree with our decision please contact the TWCC Medical Dispute Resolution.

**Issues**

1. Does the submitted documentation support billed service for CPT code 99203? Is the requestor entitled to reimbursement?

**Findings**

1. According to the explanation of benefits, the respondent initially denied reimbursement for CPT code 99205 based upon reason codes "150 and VF01."

28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

CPT code 99203 is defined as "Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A detailed history; A detailed examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family."

The requestor states "I have attached the documentation for your review. As you will see, we did meet the qualifications to be able to bill this office visit."

A review of the submitted report finds that the requestor did not meet the documentation requirements for billing CPT code 99203, specifically a detailed history, a detailed examination and medical decision of low complexity. Therefore, the respondent's denial based upon reason codes "150 and VF01" are supported. As a result, reimbursement is not recommended.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

8/23/2013  
\_\_\_\_\_  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**